ST. BARTHOLOMEW'S HOSPITAL JOURNAL

WAR EDITION

Vol. 3. SEPTEMBER 1st, 1942. No. 12

THE HORIZON

Death and the fear of it move men to undreamt of deeds. Its sudden coming excites, whereas the long agony benumbs. When eschatological doctrine was bounded by heaven above and hell below man did not cease from sinning: but in the hour of peril he called upon the Lord. To-day he cries out at the horrors of collective punishment when villages are razed, the menfolk murdered and the women and children enslaved. Meanwhile the horrider crimes proceed. For behind a curtain of blood the Nazis are procuring the remorseless extinction of one after another of the subject peoples. Glorious is the spirit which burns all over Europe, scorching the very land beneath the oppressor's foot, but alone it cannot prevail against the calculated cunning of the liquidators.

The latest of these German crimes is the intended transportation of three million Dutch to the Ukraine. While the stubborn Hollander may be expected never to submit to a Teuton overlord, the thousand miles between West and East can swallow up the proudest spirits. When Germany has been at last roundly beaten and the shackles have fallen from the nightmare millions of her prisoners, a stampede will begin in Europe which unhindered and unchecked can maim and slaughter more terribly than furious Mars. One of the earliest tasks, therefore, that the Allies must undertake is the quiet ordering of this vast mob as it seethes homeward. It must be fed, disciplined, protected from the elements and ravages of disease, and prepared for the sad ruin where it had known fields of ripening corn, friends, the marketplace and home.

Our profession will be charged with the care of the wayfarers and the control of preventable and infectious disease. Food and shelter will not alone keep epidemics at bay. Although the classic teaching of Murchison on the "Continued Fevers" has set the fashion of holding famine and overcrowding as cardinal factors in the aetiology of epidemic typhus, later observers have modified his experiences. Mackenzie,[6] in a recent paper, recognises their importance but considers that climate and, above all, movements of population have greater procatarctic significance than overcrowding, which plays a part only when famine is established.

In so far as typhus and relapsing fever, the louse-borne diseases, and malaria are expected to reach almost pandemic proportions after the war, the dangers of mass movements may be profitably studied. Not only will there be the immediate trek of returning prisoners-of-war; there will be also millions of transported civilian labourers on the way home and, over a longer period, the return of political refugees. At the armistice provision is likely to be made for the controlled exchange of combatant prisoners. Unless adequate preparation has been made, the civilians will wander across Europe as best they can, no matter what infections rage among them nor to what diseases they may be prone: nor can be foreseen the consequences of their carrying a virulent strain of some disease to an area where it is already endemic. A grim experiment on these lines was witnessed in the valley of the Volga after the 1920-22 famine:

> A large section of the population of this valley fled from starvation down to Tashkent in Turkestan, where wheat was to be bought but where malaria was widespread. After the famine, these refugees returned to their homes in the Volga Valley with their blood full of malignant malaria parasites. Malignant malaria had been unknown hitherto in the Volga Valley, and the return of the refugees was followed by an epidemic of the disease affecting 90 per cent. of the population. Very large numbers died, and the disease has remained in the Volga Valley ever since.[2]

Greenwood[5] has written that "the Greek men of science believed that illhealth was the product of one intrinsic and two extrinsic cause-groups, viz., (1) man's temperament, (2) his diet and other habits of life, (3) an 'atmospheric' influence." Modern epidemiologists call the first of these immunity, the

second procatarctic causes, and the third, following Zeiss, geomedicine. This last tends to be shrouded in more mystery than the others. Nevertheless, certain of its phenomena have been recorded with regard to typhus and malaria. In areas where typhus is endemic the disease shows a rhythmical rise and fall: it is prevalent in winter and spring, cases begin to occur as early as November and to die away with the approach of the summer solstice. The epidemic disease, however, may occur at any and at all seasons of the year, although it tends to coincide with the endemic rhythm because the louse which is always its vector pullulates in the winter and spring. Moreover, in contrast with the low death-rate of endemic typhus, the epidemic death-rate may rise as high as 70 per cent. and is nearly always above 20 per cent.; and its increase is proportionate to the seniority of age-groups. The importance of these phenomena is inescapable: the German collapse will most probably occur in the winter, when food stocks will be low and transport of relief rations difficult, and the overcrowding of homeward-bound refugees in the few inns and vehicles which will be available will provide the most likely conditions for an epidemic.

The spread of malaria, which with typhus was the principal killing disease in the four years after the Great War, is another of the epidemiological mysteries with which the Allied relief organizations will have to contend. The story does not end with the infective mosquito and the susceptible human. Although the genus *Anopheles* is the most frequent vector, not every species is infective, and, on the other hand, some innocuous species may become dangerous under undefined conditions. The belief is nearly universal that the larvæ of dangerous species exist only in stagnant pools. But they are found sometimes "in clear brooks, where they adhere to the stones, in small pools of water, cisterns or fishponds, and not only in the ill-famed flooded 'rice' fields[7]." Nor is damp a necessary condition: "sometimes, quite unexpectedly, the very dry years are the most dangerous. If there is a low water level pools are left in the dried-up river-beds, giving the most dangerous carriers an opportunity to breed[7]." The Ceylon epidemic of 1934-5 was mainly due to *Anopheles culicifacies* which pullulated under these conditions. Temperature determines the length of time over which the plasmodia develop; and seasonal change may cause hibernation and delay the appearance of dangerous mosquitoes. Mayer[7] has suggested that during the winter "Sporozoites might hibernate in some other parts of the mosquito and migrate to the salivary glands in the spring." The severity of the winter and other seasonal variations influence the harvest. When this is poor, an agricultural community such as obtains over large tracts of the Central European plain is partially starved and its resistance to every infection is lowered.

Although the re-emigration of political refugees will not be, epidemiologically speaking, so dangerous as the home-coming of prisoners-of-war and transported labourers, its significance in any plan of reconstructing Europe can be easily underestimated. Topley[10] has demonstrated the effect on a crowd of mice of introducing regularly a newcomer who is not immune to some such endemic infection as that of *Bacillus Aertrycke*: the herd immunity tends to be lowered. This phenomenon, however, will play a small part. Of much greater importance will be the value to the community of a steady stream of able-bodied men who can assist in this urgent task of recultivating the wheat fields and restarting the staple industries of the place. Moreover, in some countries, and notably in Poland, the Nazis have closed the Universities and either murdered many professional men or confined them to concentration camps, where they die in great numbers. There will be, therefore, a shortage of this class of men after the war, over and above the ordinary casualty lists; and the medical profession will be seriously affected. Owing to this closure, the first generation of young doctors cannot be expected before five or six years, even if the Universities are opened again and properly staffed and equipped very shortly after the armistice. As the political refugees included many doctors, their return will help to relieve the shortage.

Apart from the acute infections, tuberculosis and the deficiency diseases, of these latter particularly rickets, and the various causes of mortality in infancy and early childhood are becoming increasingly serious in the war-ridden Continent. In view of the doubt which has been thrown in some quarters on the current views of tuberculosis epidemiology, Dudley's studies[4] on a closed community where many cross-factors can be allowed for are of interest. He reported that the tuberculosis rate in the Royal Navy for the years 1900-13 was 2.2 per 1,000 and for 1921-34 it was 2.1 per 1,000. In spite of every effort to lower the incidence of this disease, the records have shown no improvement since the beginning of the century, up to which time the naval rate had paralleled the steady decline of the disease among the civil population. As very little had

been done to increase the living-space of ratings, Dudley has concluded that density of population is the decisive factor in keeping up the naval rate. In support of this are some further observations from miniature mass radiography, which show a higher incidence among sailors with more than five years' service than among untrained men; and the difference in the case-rate between officers and ratings. The officer rate is 1.0 per 1,000, which is approximately equivalent to the general civilian rate; and officers who have been promoted from the lower deck show this rate, whereas their non-commissioned contemporaries maintain the higher "naval" rate. Meanwhile the experience of Norwegian workers may be considered alongside of Dudley's. Ustvedt[11] has found that primary infection in the adult is followed by a danger period of about one year, during which progressive pulmonary tuberculosis is liable to appear. As he claims that the bovine bacillus has been effectively eliminated from Norway, his study is of peculiar interest in that his observations on infection with the human subspecies are not likely to have been vitiated by alimentary infection during the milk-drinking age. He moves to the further position that a previously infected patient is in no danger from exposure to massive infection, as he believes that infection and its consequent stimulation of active immunity in the host is a bar to re-infection. The development of phthisis in the adult he considers to be the outcome either of poor resistance to primary infection and the extension of the primary focus or of blood-borne tuberculous metastases which occur in an infected subject with temporary lowering of resistance from intercurrent illness or some other cause. In view of the report by Lisle Punch[9] on the aetiology of three cases of erythema nodosum, it is interesting that Ustvedt, while he recognises the various causes of this complaint, was able to confirm a primary infection with the tubercle bacillus three weeks before the nodes appeared in a number of cases.

To our knowledge of the deficiency diseases many chapters will be added by studies in Europe after the war. Milk and currant juice in adequate quantity will do much to eliminate them, but the problem of their supply is very difficult. Apart from the dangers of non-pasteurized milk—and the provision of plant for this purpose and the teaching of it to the peoples concerned constitute a big problem in itself—the real difficulty will be the shortage of cows. The Reich is said to be preserving many herds for the sake of their milk: but after another winter it is certain that they will be further depleted. Some ways of meeting these problems are considered later, together with other agricultural needs.

What has been written above is intended as a sketch of some important diseases which must be expected in epidemic proportions in the years following the cease-fire. The sooner that is sounded, the sooner charitably minded persons among the victors can get on with the job of relief and comfort to the destitute places of Europe and of the world. Meanwhile, the highest enthusiasm must be curbed by the restraints of reason: the Allies must study in detail the manifold problems of Europe-after-the-war. A start has already been made: and in two recent pamphlets issued under the auspices of the Royal Institute of International Affairs an attempt has been made to sort out in order the various difficulties which will have to be surmounted in carrying plans of reconstruction and medical relief to the Continent.[1 & 2]

Mr. Churchill made the first official recognition of post-war problems in Europe when he addressed the House of Commons on August 20th, 1940. (His words that "we can and we will arrange in advance for the speedy entry of food into any part of the enslaved area . . . including—I say it deliberately—the German and Austrian peoples" remind one of his unheeded plea for the raising of the blockade in 1918.) This recognition was afterwards confirmed and extended by the meeting on September 24th, 1941, of the Allied Governments at St. James's Palace. The subsequent entry of the United States and of Russia into the war has widened the field of collaboration and increased enormously the stocks available for filling the depleted larders of Europe. Although Russia may need more than she can easily give, she will certainly wish to take her rightful place in the counsels of relief. But before any of this work can go forward, another task must be completed:

> Neither relief nor reconstruction can be carried out in a state of anarchy. The most urgent task of all, the transportation and distribution of food, depends on the existence of a minimum of order. In some countries the objects of the Allies will be effected in association with a Government which enjoys their confidence and co-operation. In others their association with what purports to be the governing authority will require careful thought. In the case of Germany above all will it be important to know who is to rule and to keep order, not only for the fulfilment of the constructive purposes of the declared policy (which apply to Germany as to the rest of Europe), but also, and above all, for purposes of security. . . .
>
> When the Nazi régime collapses, power in Germany may pass to the Army. The Army will, on this hypothesis, be the sole surviving disciplined organisation, and even if it did not continue to exist

as a fighting force it might still be used as a police force. The inclination in some Allied quarters to acquiesce in, or even to favour, such a development might be inspired by fear of a complete breakdown of the social order in Germany through revolutionary action from within or through invasion; and such fears might be deliberately stimulated by interested German leaders. The objection to a policy of acquiescence in the government of Germany by the Army is that the victors would thereby give a new lease of life to the militaristic tradition and the domination of the military caste over German life which it has been the object of two wars to eliminate. It is essential that nothing should be done or permitted which conflicts with the cardinal aim of effectively dissolving German armed power.[1]

When authority and order have been secured on the Continent, the transportation of food must proceed with all urgency. But unless plans have been well laid beforehand, the experiences of the last war may be repeated. Some machinery for planning must be ready, and as after this war, "owing to Britain's loss of her creditor position, the U.S.A. will, with the Dominions, be even more decisively the chief supplier," co-operation with them must be sought and maintained. Together with the need of food there will be a demand for raw materials with which productive power may recommence. This matter will be so much wrapped up in post-war economy and politics that it will be difficult of solution; but on no account must raw materials be withheld on political grounds, as they form an essential part of any reconstructive work.

The conveyance of goods can be considered as shipping and as inland transport. Control of enemy mercantile marine should be included in the armistice terms, so that the Germans will be unable to use this as a lever for bargaining as they did in 1919: this will also help an Allied shipping pool in the enormous task of restocking Europe. Many ports will have been badly damaged and plans must be prepared in advance for the quick unloading and despatch of goods when they arrive. Transport across Europe will be simplified by using the military lines of communication: all convoys must be under military escort in order to forestall incidents. And there will be plenty of scope for a display of tact. For instance, it would be folly to send loads of supplies through a starving district. Railway personnel in particular should receive good rations. A likely scheme envisages a fanning-out of the distribution from the ports and other centres so that the nearer districts would get some early measure of relief: their inhabitants might then be expected to help in delivering supplies farther afield. The provision of locomotives and rolling stock will have to be made. Air transport may be reserved for carrying urgent supplies to remote parts, especially those to which access by land is impeded by snow, flood and other natural obstacles.

Medical relief is an enormous problem. But one of the first and most important considerations is not so much the material and manner of relief as the actual staffing of the organization. This should include two groups of medical men:

The first should consist of a number of senior medical advisers, whose names and experience would command respect with the various governments and who, after visiting different countries to ascertain their problems and needs, would report to the headquarters of the organisation. Secondly, an executive staff of younger doctors would be required for the field work. Too great care cannot be lavished on the choice of these doctors, as in addition to energy and technical knowledge it is of fundamental importance that they should possess tact, devotion, and the ability to work with foreigners. A knowledge of languages is, of course, a great advantage, but is of secondary importance to the three qualifications already mentioned. Above all, care must be taken to avoid the employment of "adventurers"; many of this type have proved misfits in their professional work, and are often the first to make application for an appointment. In addition to working with the government of the country concerned, any medical officers engaged on relief work would, of course, obviously require to keep in the closest possible contact with the general practitioners and consultants.[1]

The question of malnutrition is of first importance. Firstly, the degree of undernourishment must be assessed, and at the outset the profession is handicapped by the absence of any reliable "nutritional standard which can be applied on a wide scale in the field." In Europe there will be two classes of malnutrition: the industrial and urban areas, where the degree of undernourishment will vary with the locality; and the country districts, where acute starvation will be liable to occur. In connection with this second group and sickness, Pickles' words return with added force[8]:

I read not long ago that the appalling death-rate in the well-known epidemic of measles in Fiji was due not so much to its being a new disease for which there was no inherited resistance, as on account of the lack of nursing facilities, and that, owing to whole families going down simultaneously, the very necessaries of life could not be provided. The "controls" in this epidemic were the members of the police force, whose conditions of living were entirely different, and who therefore showed a death-rate not above the normal. In some of our isolated farms during an influenza epidemic a state of affairs similar to that exhibited in Fiji was faithfully reproduced. The house was as cold as a vault, as not a single member of the family was in a fit state to crawl downstairs to light the kitchen fire. Food had been for days a difficult problem, and hot drinks an utter impossibility. Neighbours are very good, and at our request this was soon remedied, but with the inevitable result that the disease spread to the homes of the good Samaritans themselves.

Mackenzie suggests that malnutrition can be assessed by adopting four lines of inquiry:

(1) by study of the existing social conditions; (2) by a widespread inquiry of the average food consumption in twenty-four hours; (3) by studying the physique of the children; and (4) by investigating the types of nutritional disease which are prevalent in hospital and clinical practice. The distribution of food must depend on the results of some such investigation. In places where the country districts are fairly well provided for some advantage may come from adapting the English evacuation scheme. But these places are likely to be few and far between. Milk is an essential of children's diet. While cattle are being imported and herds got together, the situation can be met by the use of dried milk and of fruit juices. The allocation of rations in a famine must proceed with strict impartiality. First of all the members of the relief organisation must get their food regularly: all delinquents must be punished, if the occasion arises, with dismissal. Secondly, the organization must be resigned to relieving certain groups of the community and it must not fritter away the resources by inadequately feeding everybody. In the countryside stores must be built up in the summer months and transport must be arranged. Horses are very helpful and should be imported; they were invaluable in the Volga Valley famine of 1922.

Malaria and typhus are the two great dangers so far as epidemic disease is concerned. Of the diagnosis of typhus, Mackenzie[2], who has had wide experience of it in South-Eastern Europe, Russia and China, says that "even under the best conditions (it) may be exceedingly difficult, especially in its early stages. This is due partly to the fact that the rash does not appear until the fourth or fifth day of the illness, prior to which typhus is indistinguishable from several other diseases, and partly because, during an epidemic, typhus frequently occurs in an individual who is already suffering from some other disease such as malaria, typhoid or relapsing fever. The last, particularly, is commonly epidemic at the same time as typhus, inasmuch as it is carried by the louse and is consequently favoured by the same conditions." As there is no protective vaccine which has been proved to be efficient, the disease has to be stamped out by destroying the vector. Mackenzie gives a full account of the methods of typhus control and stresses the importance of adequate protection of the relief personnel. These should be recruited from young persons, preferably under thirty, and, where it is feasible, from those who have either had the disease or lived a long time in an endemic area. Although an epidemic of typhus can be greatly reduced by disinfestation measures, these alone are never completely effective, and the relief of famine must always play a major part in stamping it out. Moreover, the Rickettsia virus is sometimes airborne and inoculation has occurred through the conjunctiva, and through the respiratory tract. In typhus areas the population is often illiterate: here the radio can help the relief worker by simple instruction and the encouragement of cleanliness. A very large supply of soap should figure prominently in all relief plans.

Malaria has to be combated by anti-mosquito measures and by the adequate administration of quinine. Some of the snags of the former have been mentioned already: the waste due to efforts at exterminating harmless mosquitoes should be emphasized, together with the need for a competent entomologist in every relief party. Quinine is invaluable, provided that it is not squandered. The occupation of the principal sources of cinchona by the Japanese increases the difficulties of building up stores. But even if it is delivered to centres of distribution on the Continent, that is no guarantee of its being adequately used. Clark[3] has quoted the experience of the French Army in Macedonia in 1915: "Quinine was provided but its consumption was not enforced, and in 1916 the army was immobilised by a malaria rate of 2,000 cases per division. The prophylactic use of quinine was stated to have failed completely until the medical service, by means of urine tests, proved that only 15 per cent. of the troops were taking the drug regularly. Quinine administration was then enforced as a matter of military discipline, and in 1918 the malaria rate had fallen to 125 cases per division, whilst the urine tests showed that 90 per cent. of the troops were taking the drug." A further disadvantage of quinine is its inability to destroy the sexual forms (gametocytes) of malignant tertian, and it cannot be guaranteed to stop the spread of the disease. But its virtues lie in its comparative safety and in its sufficiently curative effects to allow of most sufferers returning to their work. Then they can get on with the job of producing sufficient harvest to protect the community from the ravages of the following winter. In those places where rebuilding is going on doctors should advise on the siting and building of villages in malarial regions, as this is an important aspect of prophylaxis. Finally, the words of Nocht and Mayer[2] may be applied not only to malaria but to all disease with which the physician has to deal:

> The human factor also plays an important part. Human conditions of life, the degree of civilisation, and the standard of living make men more or less susceptible to malaria. More civilised races tend to treat each individual case of malaria; less civilised peoples are usually less inclined and less able to do

so. Therefore they become as gametocyte carriers, a source of infection for the mosquitoes, *i.e.*, a link between the yearly occurring outbreaks. The possibility of new mosquitoes becoming infective depends upon the number of gametocyte carriers at the appropriate time of year. In sparsely cultivated tropical and sub-tropical countries this opportunity of infection is usually present. Rodenwaldt and Swellengrebel are right in saying: "In the end the epidemiology of malaria cannot be entirely explained through plasmodia and anopheles. The economic and nosographical conditions of life of a population exposed to infection are an important, often even a decisive factor."

All this goes to show that each malaria district has its peculiarities. To fight malaria, doctor, entomologist and engineer must co-operate in measures recognised as suited to the local conditions. The entomologist must first discover the species of anopheles and their life histories. Parasitological examinations must identify them as possible carriers (sporozoite index). With the result of those investigations the doctor must compare his own observations on the population, the extent, and the variety of the malaria.

War on malaria means the advancement of civilisation. It is to be hoped that the "world war against malaria" for which science has given us many new weapons and a strategy, will lead to victory in peaceful competition between the nations.

REFERENCES

1. Relief and Reconstruction in Europe: The First Steps. An Interim Report by a Chatham House Study Group. The Royal Institute of International Affairs, 1942.
2. Medical Relief in Europe: Questions for Immediate Study. By Melville D. Mackenzie, M.D. The Royal Institute of International Affairs, 1942.
3. A. J. Clark: Applied Pharmacology. 7th Edition, 1940. J. & A. Churchill.
4. S. F. Dudley: Proceedings of the Royal Society of Medicine, Section of Epidemiology and State Medicine, XXXIV. 7, May, 1941.
5. M. Greenwood: Epidemics and Crowd Diseases, 1935. Williams & Norgate.
6. M. D. Mackenzie: Proceedings of the Royal Society of Medicine, Section of Epidemiology and State Medicine, XXXV. 2, November, 1941.
7. B. Nocht and M. Mayer: Malaria. English translation, 1937. John Bale.
8. W. N. Pickles: Epidemiology in Country Practice, 1939. John Wright.
9. A. L. Punch: Brompton Hospital Reports, Volume X., 1941.
10. W. W. C. Topley: An Outline of Immunity, 1933. E. Arnold.
11. H. J. Ustedt: Pulmonary Tuberculosis. English translation, by A. L. Jacobs, 1942. John Bale.

THE "FIRST M.B."

By J. C. V. WILKES

The writer of this article is not a scientist: he is a Head Master who has seen a large number of boys preparing for a medical career, and who is perhaps biased by his own love of classical and modern literature in favour of a more general education at school than it is possible nowadays to give to such boys: and he knows that a number of other Head Masters (and some doctors) share his views. Here they are for what they are worth.

First—some matters of detail. Under the present arrangements there is overlapping between Sixth Form work at school and work at the University. There is not proper co-ordination. Further, there is sometimes conflict between the Higher Certificate course, preparation for scholarship examinations, and the First M.B. courses. Exemption from the latter by means of Higher Certificate is often uncertain, varying from one medical school to another. An exemption certificate or examination qualification may be accepted at one medical school and not at another. The syllabi of the various First M.B. examinations differ—and though the actual differences in *content* are inconsiderable, the differences in the emphasis placed on different subjects *do* vary very much, and the standard demanded varies also. It is impossible not to feel a suspicion that the standard demanded varies with the number and quality of the candidates, a medical school raising or lowering its standard so as to be able to exclude, on the grounds of failure to reach that standard, boys for whom it cannot find room.

This last point is particularly important. A schoolmaster cannot tell in advance what the standard at a given medical school in a given year will be. He feels that the examination will be in fact, if not in name, competitive. He cannot, therefore, safely recommend a pupil (unless he is particularly able) to postpone intensive specialisation in the necessary subjects for a year or more after taking the School Certificate—say at the age of 15½ years. Even if the schoolmaster thinks this may be done without risk, the parent may not be prepared to agree. Early specialisation is therefore inevitable; and early specialisation in *any* subject—Science, Mathematics, Classics, Modern Languages or History—is generally recognised to be wrong.

The demands of the Universities on scholarship pupils in *all* subjects make it hard to avoid early specialisation at school; but harder in

Science subjects than in the other because it seems more difficult for examiners to set papers in Science that test promise and not knowledge than in other subjects. Clearly a competitive examination for a boy of 17 or 18 years *ought* to be made to test promise. If, therefore, the First M.B. examination is competitive in fact, it should be a boy's promise that is tested, not his knowledge; if, on the other hand, the examination is *not* competitive, it should have a definite and known standard of knowledge required, all examining bodies should require the *same* standard in the *same* subjects. The schoolmaster would then know where he was. But the writer himself believes that it is better to test promise than knowledge, and that papers should be set which enable the examiners to distinguish the able from the indifferent, not the crammed from the ignorant.

The medical profession is one of the learned professions. Its practitioners should be men of intelligence well above the average. No hope or inducement should be offered to men of inferior ability—they should not be enabled to "scrape through" preliminary examinations for the profession by early and intensive specialisation. If they are able to do so, either they will fail at the next hurdle, and then have to turn round and discover some other profession, having wasted years of their time in studying subjects which will be of no particular value to them afterwards; or else they will continue to scrape through, and there will be turned loose on the public a number of inferior doctors. It is far better to make sure that only the really able *can* enter the profession, at the start. How is this to be done?

It can only be done, the writer believes, if the qualification for entry, while including a definite minimum standard of knowledge in scientific subjects, includes also either other examination tests, by which ability can be judged, or (or perhaps "and") a recommendation from the Head Master that the boy has real ability. Such examination tests would inevitably be in other than scientific subjects, and would involve education in such subjects up to the time of leaving school—since without such education the ability, however great, is likely to remain latent. All schoolmasters know how often a really able boy, concentrating on scientific subjects after the age of 15, is unable to express himself lucidly and idiomatically in his own language, and has his mind crabbed and confined and stunted by an insufficient diet of literary, historical, linguistic studies—his horizon becomes narrowed, and his capacities atrophied. Lack of variety in his fare will cause indigestion or flaccidity.

To all this it will, of course, be objected that the content of the whole medical syllabus, from the First M.B. to the final examinations, is now so vast—and becoming vaster every year—that it is necessary for the would-be doctor to begin an intensive study of scientific subjects early; otherwise he will not have acquired the necessary knowledge until he is even older than he would be in present conditions—and that, it will be argued, is already too old, because it means that the parent has to continue to support his son—and support him at considerable expense—until he is well on in the twenties. Economic difficulties will decrease the already small numbers of parents who are prepared to go on supporting their sons in this way. They will indeed: But this is no argument for maintaining the present system. A far more radical change is necessary.

Already the medical profession is only (save in exceptional circumstances) open to the children of the well-to-do. This is not only wrong from the democratic point of view; it also limits the number of *able* men available for the profession. It is essential that the State should intervene, and should provide the means whereby all suitable candidates, whatever their parents' incomes may be, can complete the full medical course, however long it may take, such provision being made (by scholarships, etc.), on a means test, from the age of 17½, and granted to all boys who have proved by their performance in the examinations and their record at school that they are fit persons for the profession. The scholarship would of course be withdrawn should the pupil show by his subsequent conduct or progress that he was *not* earning the grant. It is probable that after the war all pupils at secondary schools who are thought capable of benefiting by a University career will be enabled by the State to enjoy such a career, whatever their parents' means. It would be but an extension of this principle to subsidise the medical student to the age of 26 or 27.

"26" or "27" may seem to many to be a late age for a man to begin to learn his living. To this there are two replies possible: first, that the whole trend of modern civilisation (and a desirable trend) is to extend the period of education for the more intelligent citizens—a course advocated by Plato in the "Republic." Secondly, it would be possible to shorten the course, providing the qualified doctor with a job at the hospital for a couple of years—during which he could gain the extra knowledge necessary—before he was allowed to go into private practice. Refresher courses of six

months a year could later be provided, and might well be made compulsory when, say, the doctor had been five or seven years in practice, the State subsidising such courses, and the profession providing substitutes to take the place of the practitioner during his absence at the course. The need for such " refresher " courses in all professions—or at any rate their desirability—is obvious enough. It is essential that men should keep " up to date " whatever their profession.

" But what," we may be asked, " is really the objection to intensive specialisation from fairly early years? Is it not better to become an expert in one subject, than to have a mere smattering of many? " The answer to this involves more fundamental problems. All men, whatever their profession, whatever their chosen subject of study, are first citizens, and only secondly experts in some branch of knowledge. This is true even of the research student: it is far more obviously true of the doctor. Scientific knowledge is indeed necessary for a doctor; he must be abreast of the latest developments of scientific thought, and must be qualified himself if possible to add to the volume of scientific knowledge. But a doctor has to deal not only with material things —men's bodies—but with psychological and spiritual things too—with men's minds. He must understand his fellow men. Physics, Chemistry, Biology, Physiology—all deal with the material world. History and literature—English and foreign literature—deal with people. An education which neglects literature and history (and philosophy, for that matter, though philosophy is not a fit subject for the immature mind) is incomplete, and dangerously incomplete. It is dangerous for education to neglect science, of course—all men, whatever their profession, should know something of scientific methods and achievements; but the neglect of the " humanities " is the more dangerous of the two. The doctor, above all men, should be a complete man; he should be at home in the world of books, for through that familiarity he can be at home in the world of men.

What, then, should the pre-University or pre-medical school education of a future doctor be? When a boy goes to his secondary school (at the age of 11) he should begin to study Science—" General Science," with the greatest emphasis on Biology (this will begin as " nature study "). Two years before taking the School Certificate (at 13-14) he will have eight or ten periods a week at the Physics and Chemistry required in that examination. In his last two-three years at school he will spend two-thirds of his time on scientific subjects, the other third on history, a modern or an ancient language (preferably both, and preferably Geek as the ancient language, for obvious reasons), Scripture and English; he will be encouraged to read widely in his leisure, and given leisure in which to read. At $17\frac{1}{2}$-$18\frac{1}{2}$ he will qualify for acceptance at a medical school, satisfying the examiners that he has the necessary background of scientific knowledge, and armed with a recommendation from his Head Master. He may also be required to write an essay and answer a General Paper—a high standard being expected in these papers. The same examination will serve all Medical Schools: scientific knowledge beyond the requirements of the examination will not be expected—and the requirements will be well known; so that the really able boy who has attained the necessary standard by the age of $16\frac{1}{2}$-$17\frac{1}{2}$—can in his last year at school have a wider and more general education—or can spend the year after the School Certificate in the study of the Classics, of Modern Languages or of History. Preferably the last year at school would be the time when he could have a comparative holiday from Science. In the happier days of peace such a year might be spent abroad, at some University where he could continue his scientific studies to some extent. Having qualified, he would receive a State scholarship or bursary, and be able to go either to a University or to a hospital, without being any financial burden to his parents. The exceptionally able would be encouraged (and enabled by a generous grant) to study for a year or more abroad after they had passed their final medical examinations. No doubt the cost to the State of such a scheme would be considerable. But it is hard to think of a better investment for the money. Money spent on education is always money well invested—if the education is good; and spent on medical education it would be the best investment possible. A system which enabled really able men to study medicine, whatever their parents' means, and to study it in a liberal and leisurely manner, must repay the country over and over again. Quite rightly, the medical fraternity has been looked up to, as a society of unselfish, wise, and enlightened servants of the community. To make it as easy as possible for the doctor to be wise, enlightened, cultured, instead of placing as many obstacles as possible in his path (for instance—a highly specialised and rather narrow course of education, a desperately busy life immediately after he has qualified) is the least the community can do to show that it recognises its debt to this profes-

ABERNETHIAN SOCIETY

This summer the Society has had lectures from two distinguished men. On May 21st Professor J. Chassar Moir gave a lecture called "Ruminations." He said that he held the reputation of Bart.'s in such high esteem that he dared not take a clinical subject for fear he met his Waterloo. His theme was to examine what each preceding generation had lacked in its armamentarium for attacking disease. He then chose three men from successive generations who had contributed to the advance of medicine. They were Roengten, Lister and Simpson.

Roengten was an outstanding worker who had followed up the experiments of Faraday and Crooke and had discovered the X-ray. He secreted himself for three weeks and at the end of that time he wrote a paper with eight points about the new ray. To-day those points are still essentially correct. The Professor showed some amusing slides which demonstrated the way the public had interpreted this discovery. Shops even advertised ladies' bathing dresses which were impervious to the new ray.

Lister did not spring to fame in the same dramatic fashion. This "king among men" had to fight from the moment he though of his revoluntionary ideas. Even though it was a winning battle that urged him to greater effort, the core of the medical world remained adamant. The London schools would not accept his teaching. So Lister bravely bearded the lions in their den and became Professor of Surgery at King's College Hospital. The story is told of an Austrian professor who enquired of a student at a big London hospital the whereabouts of the Lister who had revolutionised surgery. The student replied that he had never heard of Lister, and anyhow he certainly was not in his hospital.

Simpson, too, had to fight. He suffered from financial difficulties and had the misfortune to make many enemies. There is still some doubt if it was Simpson or his assistant who first discovered the anæsthetic properties of chloroform. But it was certainly Simpson who bore the attack from the scrupulous and the religious. Simpson had the skill and the wit to defeat his opponents with their own weapons. It is common knowledge that he pointed to Genesis for the first example of anæsthesia.

The Professor finished his lecture by comparing the three men. Roengten and Simpson had been lucky enough to discover certain physical properties and they had been alive to their meaning. But it was Lister who was the genius; for he had the brilliance to apply a discovery in the then widely separated field of bacteriology to surgery and then the strength of his convictions to carry away all opposition.

Dr. Beattie, proposing a vote of thanks, said that at some future meeting another lecturer would refer to Professor Chassar Moid for his discovery of ergometrine. He hoped that if any anecdotes were told about the Professor it would be remembered that he invariably fell out of the punt at a picnic.

On July 23rd Professor Himsworth lectured on "Diabetes—Human and Experimental." He began with a review of the last century, when Mehring and Minkowski showed that pancreatectomy caused a condition identical with the disease diabetes mellitus occurring in man. He told of the series of experiments leading up to the discovery of insulin from the islets of Langerhans. At that time it was thought that diabetes was caused by the absence of something. But the work of Houssay in South America showed that diabetes could be caused by giving extracts of anterior pituitary to an animal. This implied the presence of an anti-insulin factor.

The Professor then mentioned the three ways that diabetes could be caused experimentally in an animal. The animal could be pancreatectomised, it could be partially pancreatectomised and then given massive doses of carbohydrate, or anterior pituitary extract could be given.

Turning to human diabetes, the Professor said that it was now known that there was no such thing as the glucose value of insulin. By determining the glucose equivalent, the insulin tolerance and the hunger day in each patient, the Professor had been able to show that there were two kinds of diabetic. The first was insulin sensitive and able to utilise his insulin to a far greater degree. The more carbohydrate in the diet the more work each unit of insulin did. In the insulin insensitive type this did not happen. From these experiments the insulin-glucose test had been devised in order to classify patients.

Continued from p. 196.

sion: and the debt will be greater still if the obstacles *are* removed so far as possible. For us laymen to treat the doctor generously in the matter of education is but enlightened self-interest.

The mode of action of insulin was then considered, and it was shown that insulin caused a greater absorption of glucose in the peripheral tissues. But anterior pituitary extract inhibited the action of insulin if the liver had been removed. So far in acromegaly and Cushing's syndrome a similar acting anti-insulin factor had been found, but in the case of insulin insensitive patients nothing had come to light.

At the end of his lecture the Professor answered the many pertinent questions asked. This discussion added greatly to the value of the lecture and showed that many had followed the arguments put forward. Professor Christie then thanked the lecturer on behalf of the Society for making a subject that had been simple ten years ago so complicated in so lucid a manner.

The next meeting of the Society will be in September, when Professor Grey Turner will lecture.

R. J. H.

* * * *

THE BRAINS TRUST

The Abernethian Society held its third Brains Trust on July 23rd in the Nurses' Home; the members of the Trust were Sister Paget, Dr. Roxburgh, Mr. Capps, Mr. Grey Turner, and Mr. Smith, and once more Mr. Harmer supervised the proceedings as question-master; he introduced each member of the Trust in turn, with customary brilliance, at one moment emphasising the importance of baldness and piles, at another physiology, while always he possessed the pleasant knowledge that there could be no repartees to his badinage; however, the Trust emerged from this storm of banter more or less unruffled, and well-prepared for the evening's great tasks.

Humour pervaded the room, partly in the questions, partly in the answers, but mostly in the audience, who fully appreciated the clever replies of the Trust; the knock-out question was a knock-out, but the Trust managed to explain it away by asserting that there was no physiologist with them. Some interesting theories were put forward, as also for the next question concerning the aetiology and variations of ticklishness; full credit must be given to the questioner, because it caused great internal disorder among the Trust; some denied it, some denied this, some were ticklish, and others were not, and the skin department could not throw much light on the matter; this, too, was thrown on to the shoulders of the mythical physiologist —unfortunate man. The conclusions were that it was partly physiological and partly due to the man of the world!

The next question was rather a disappointment, as it concerned the two most important post-war changes that were most necessary: it was interesting to hear the views of these medically-minded persons, who did not emphasise the importance of health generally, but rather of better education, which was particularly stressed, although better milk and better wages were also suggested; no satisfactory conclusion could really be expected, however, from a question which is puzzling the experts of the whole world.

Much to everyone's surprise, the expert photographer on the Trust denied that photography was an art, the subject of the next question; in this, however, he differed from the remainder of the Trust, so perhaps it was from modesty that the answer was coined; this seemed one of the most straightforward questions, though perhaps there was more to it than met the eye—or the camera!

High heels was the subsequent question, and its bearing on women; much lively talk was exchanged, although there was a marked favour towards them, and the whole topic was summed up excellently by one speaker, who finished with the quotation that better wives have higher heels.

After the questions came second thoughts, when information about previous puzzles were elucidated; the Trust provided a thoroughly enjoyable and amusing evening and none will deny that it undoubtedly "mixed reason with pleasure, and wisdom with mirth."

Mr. R. J. Harrison has become Assistant Editor to the JOURNAL; Mr. A. V. Livingstone has become Manager, in succession to Mr. G. E. Hicks, who did a signal service to JOURNAL finances.

NOTES ON THE TEACHING OF OPHTHALMOLOGY

By A. Seymour Philps.

* Advances in the treatment of eye disease depend upon early and accurate diagnosis. The responsibility for this rests primarily with the patient's own doctor. Therefore, the chance to benefit thousands of future eye patients lies now with those who teach ophthalmology to students.
* There are some born teachers who can hold the interest of their pupils in any surroundings, but most of us need the right conditions of air, space, light and quiet before we can do justice to ourselves and the occasion.
* It is not possible for one person to teach junior students and at the same time to treat and refract patients. A colleague must therefore treat and sift the patients, passing on those suitable for teaching after their condition has been treated and their refraction worked out.
* The eye is a small organ and not more than six students can usefully be taught by one person. More cannot see and the patient will be tired by too much examination.
* The early detection of such diseases as glaucoma and detachment of the retina means, literally, the difference between sight and blindness for the patient. To recognise these diseases students must have a better grounding than they sometimes now receive.
* Mistakes in diagnosis are made not so much from lack of knowledge as from inadequate examination. The physical sign that is missed may be only "a small one." The housemaid's baby was only a small one, but a baby just the same.
* The examination of the eye, externally and ophthalmoscopically, is a matter of practice. No one will see much with an ophthalmoscope on the first few occasions. He should be taught how to use it at the beginning of his clinical training.
* In ophthalmology inspection is everything, palpation less important and auscultation and percussion useless. Unable to make use of touch and hearing, it is vital to teach the student how to use his eyes to the best advantage.
* The time to start learning to use the ophthalmoscope is when the student first enters the wards, NOT after he has left them. He will then, by regular practice, be in a position to avail himself of the material which comes before him in the eye department on the few occasions on which he may attend.
* One session in the eye department at the beginning of his clinical work would suffice to show the student how to examine an eye, and save him from many mistakes later on.
* He might then be tempted to acquire an ophthalmoscope and practice its use. Too often now it arrives after he leaves the eye department.
* There may be "nine and sixty ways of constructing tribal lays," but there is only one right way of using the ophthalmoscope. This again could be taught him when he first examines patients.
* There is no need to practice the examination of the eye exclusively on eye patients. Much better try it out on ward cases with no eye disease.
* One patient examined, understood and remembered is worth twenty lectures.
* Even so, lectures are useful under the right conditions, for there will be much that the student has no chance of seeing and examining.
* The chief of these conditions for an eye lecturer is an epidiascope. It may be possible to convey an adequate picture of a Potts fracture with blackboard and chalk. It is *not* possible to draw a picture of acute glaucoma, and the attempt to do so will waste a lot of time.

ON ACTIVE SERVICE

ROGERS.—Missing in June, 1942, in Libya, Capt. M. C. Rogers, R.A.M.C., attached A.T.R.

BOOK REVIEW

BROMPTON HOSPITAL REPORTS. A Collection of Papers recently published from the Hospital. Volume X., 1941. (Pp. 127. 5s. 7d. post free. Copies can be obtained from the Secretary, The Hospital for Consumption, Brompton, London, S.W.3.)

This volume follows the principle of preceding volumes in collecting together the papers published by members of the hospital staff during the year, and therefore serves a very useful purpose for those interested in chest disease. It does, however, include one paper —"The Persistence of Lipiodol in the Lungs following Bronchography" by F. H. Young and E. Gantz—which has not previously been published. In this article the authors describe the changes found in lung tissues removed by operation in which iodised oil had been retained. Section of the areas containing oil showed inflammatory changes either in an active cellular stage or in a stage of fibrosis. The reason for this inflammatory reaction was investigated. They found that in vitro iodised oil in contact with sputum and kept in the dark underwent hydrolysis and oxidation resulting in the freeing of fatty acids. These might be the cause of the irritation. The authors also showed that iodised oil has little or no antiseptic properties, and suggest that the inflammatory changes might also be the result of the oil carrying bacteria into the more peripheral parts of the lung. The paper is apparently an interim report and should serve to prevent bronchography being performed in the absence of adequate indications. The evidence that iodised oil is the cause of definite inflammatory changes is not proven beyond question, as the lungs or lobes removed were naturally the site of pre-existing infection; however, the localised inflammation found around droplets of the oil certainly favours this contention.

The reprinted articles include three connected with war-time surgery—"Drainage of the Pleura" by R. C. Brock, "Closed Wounds of the Chest" by J. G. Scadding, and "Traumatic Hæmothorax" by C. Hoyle. The first is applicable to pleural infections apart from infected hæmothorax and should be read carefully by all those who "do an occasional empyema"—and particularly by writers of standard surgical text books! A. F. Foster-Carter's article on "Bronchial Adenoma" is included; this sums up most clearly the clinical and pathological features of an insufficiently recognised condition and includes an analysis of 22 cases admitted to the Brompton Hospital.

The paper by A. Lisle Punch entitled "A Note on the Aetiology of Erythema Nodosum" is a report of three nurses entering hospital with a negative Mantoux reaction which subsequently became positive with the development of erythema nodosum.

The other articles reprinted are: "The Aetiology of Sub-acute Pulmonary Infections" by Maurice Davidson and Philip Ellman, "Some Notes on the Treatment of Carcinoma of the Bronchus" by F. C. Ormerod, "Medical Aspects of Chronic Empyema" by J. G. Scadding, and a case of "Primary Chondroma of the Bronchus" by Maurice Davidson.

F. C. Ormerod's paper brings up to date his experience of the treatment of bronchial carcinoma by intrabronchial radon. The results are not very hopeful, but anyone who makes a serious bid to treat this depressing and only too common disease deserves every encouragement. To have two proven cases alive and well eight years and five months after treatment certainly justifies the urge to continue trying his form of treatment.

The volume as a whole maintains the high standard expected from this hospital.

HILL END NEWS

At the time of writing this news we are still waiting with increasing anxiety for a sign that summer is at last upon us. It is to be hoped, however, that by the time this is in print there will be no doubt about the matter.

In the intervals between the showers we have been playing a considerable amount of tennis, and the cricket is equally flourishing. We are still flushed with our victory over a team from Bart.'s, but even in this match we felt that the total triumph might be snatched from us by an appeal against the light which would indeed have stood a good chance of success. We feel that we must congratulate the member of the Hill End side who pulled off a hat-trick, thus bringing the match to an unexpectedly rapid conclusion.

The Dramatic Society has shaken the dust off

its backcloths, and a new production is in preparation for the end of September. Once again one expects to hear the sound of hammering and scene-shifting coming from the Reception Hall; and if one ventures in, a knot of stage hands may be seen admiring a set of stairs precariously balanced on boxes in the middle of the stage. Noel Coward's " Hay Fever " is the play chosen, and rehearsals at the time of writing are well under way. We have every expectation that the standard of previous productions will be well maintained.

The Choral Society, too, has re-awakened and works of all kinds, from Haydn to Sullivan, are being practised regularly. A concert should be ready by the last week in September, with Parry's " Blest Pair of Sirens " as the main work.

On August 8th the Gramophone Society enabled a party of 30 students and nurses to visit the Albert Hall for a Prom, at a reduced price. The programme included Beethoven's Seventh Symphony and the first performance of Norman Demuth's " Valses Grave et Gaies," and although we were perched up near the roof, the acoustics were extraordinarily good.

Apart from the mention of a recent A.R.P. exercise—the most memorable feature of which was a most welcome cup of tea at its termination—there is nothing else to report.

MISS CUTLER

Miss Cutler, Assistant Matron from 1907 to 1920, died at St. Bartholomew's Hospital on August 4th, 1942.

Three months of acute suffering brought out her sterling qualities of stoic fortitude, endurance, patience and consideration for others. Those of us who knew her " in office " realize that a stern exterior hid a very gentle heart: a disciplinarian of the old school, but who moved with the times and appreciated the needs of the present generation of nurses.

Miss Cutler started her training under Miss Manson — now Mrs. Bedford Fenwick — obtained her Hospital Certificate in 1888, and then the Certificate of the London Obstetrical Society, which at that time took the place of the present Certificate of the Central Midwives' Board. On the instigation of the late Miss Isla Stewart, Miss Cutler went out to Egypt to do pioneer work, and was appointed Matron of the Government Hospital at Cairo. There she had countless difficulties to meet and overcome; a hospital of 850 beds, native nurses and orderlies, unable to speak English. After 13 years' work in Egypt, she returned to England and was appointed Matron of the Much Wenlock Cottage Hospital until she returned to her Training School for two years as Superintendent of the Nurses' Home and then as Assistant Matron.

During the last war, Miss Cutler, in answer to an appeal for help from Belgium, took a unit of 15 nurses to Brussels to work with the Belgian Red Cross. They were all taken prisoner and compelled to nurse the Germans, but later escaped back to England. She was awarded the " Mons Star," Victory Medal and a French medal presented by Monsieur Clemenceau. On the outbreak of this war, Miss Cutler was in South Africa, and against the advice of her relatives and friends she made up her mind to return to England, which she did in the summer of 1940, alone, at the age of 79 years. She immediately resumed her activities in connection with the Hospital, coming up each week to work with the " Splint Making " Party in the Out-Patieut Department, and bringing flowers and vegetables from her garden for the Nurses' Home and Dining Room.

Miss Cutler took a keen interest in the organisation of the founding of the International Council of Nurses, and the fight for the State Registration of Nurses. She was Honorary Secretary for many years of the League of St. Bartholomew's Hospital Nurses, a Vice-President of the League, a Fellow of the British College of Nurses and a member of the Council of the Royal British Nurses' Association.

The Funeral Service was held in the Church of St. Bartholomew-the-Less, attended by many of her colleagues, friends and present Staff. The soul of generosity, always thinking of others, a " grand old lady "—May she Rest in Peace.

CORRESPONDENCE

To the Editor, St. Bartholomew's Hospital Journal

Dear Sir,

I have just read your last Editorial, and must protest.

Instead of finding something remotely connected with the subject of medicine, or even with Bart.'s, I am obliged to sort out a meaningless jumble of clumsy words, constituting a type of bitter article which I can read any day in the more popular of the daily papers, without being bothered by "pusillanimous whimperings" and people "recanting iotas."

If indeed, as you say, you have "frequent recourse to the works of an Englishman," could you not use such a work for a better purpose than finding long words and phrases which are meaningless to simpler souls than yourself?

I am not ashamed of my own ignorance, especially of the meaning of the word "fatuosity," which does not appear in my "Concise Oxford Dictionary"; and I am unable to find out from any source what a "poodle-faker" is.

Your unintelligible style resembles closely that of the official documents and forms issued by the "puling politicians" whom you so vigorously decry.

As a disciple of the Hon. Member for Oxford University, in his great campaign for better English, I say in disgust, "What words!"

Your, etc.,

JOHN M. POTTER.

Thank you for your letter and frank comment. I am disappointed that you did not discern the spirit in which my leading article was written. Does Mr. Herbert allow of your "reading between the lines?" Had you tried this somewhat hypothetical practice you might have recognised the gentle art of parody. But there again I am probably requiring of your Saxon knut an intelligence and a grace which are strange to it.

To the Editor, St. Bartholomew's Hospital Journal

Dear Sir,

During one week recently I attended 15 teaching classes (lectures, out-patients and ward rounds) at Bart.'s and at Friern. Of these, only three started at the advertised time, and in all precisely two hours were spent in waiting for the lecturer to appear. The average number of persons present was certainly not less than thirty, so that the aggregate of time wasted was considerable. I do not wish to appear churlish by criticising our over-worked chiefs at a time like this, but I am quite sure that a little more regard for punctuality would produce in return a more responsive set of students.

Another matter which has been causing some concern lately is the apparently inconsequential manner in which out-patient clinics are cancelled without notice. Quite frequently there is no alternative teaching available, with the result that a morning is wasted, to say nothing of the expense of the train journey to get to the hospital.

I sincerely hope that these remarks will not be taken amiss by our chiefs, but as an earnest of our desire to waste as little time as possible.

Yours sincerely,

SCHOLASTICUS CUNCTATUS.

St. Bartholomew's Hospital.
August 17th, 1942.

SIR HAROLD GILLIES

The JOURNAL regrets that, in the two lists of Out-patient Clinics which it has published, no mention was made of Sir Harold Gillies' Clinic on the first Monday of the month at 2 o'clock in the afternoon.

SPORTS NEWS

CRICKET

Rahere Rovers v. St. Mary's.

On May 31st, George Ellis, as non-playing captain, led a motley band to Teddington to battle with an array of Mary's talent. A hearty welcome having been extended to Trevor James (our guest artist), the Rovers took the field, and N. O. Bennet and Peter McRae took themselves a large slice of cake, to wit, 34 and 76 respectively. At Beer interval Mary's declared at 157 for 5, leaving Ellis' prodigies an hour and a half to make the runs. The sight of the Rovers' opening pair in brown boots and one pad each lulled the enemy into a sense of false security sufficient to allow Hicks to drive the opening bowler well over the sight screen. Mary's were quick to perceive the deception, however, and then dispatched the first five batsmen for 45. Gray and Hunt carried the score to 115 before being tempted by Watson. With one over to go the Rovers still required ten runs, and it was left to Harold and Moffat to mix stolid defence with defiant hitting. With five runs to make, stumps were drawn, and the beer being of inferior quality the party returned to Bart.'s to win a moral victory in the Vicarage.

Scores: Mary's 157 for 5 dec.; N. O. Bennet 34, F. M. McRae 76, T. James 3 for 21. Rahere Rovers: G. Hicks, b McIntosh, 11; H. G. Middleton, b Kemp, 5; F. G. Morse, b Watson, 13; V. H. Jones, c, b Kemp, 3; R. McGrigor, c and b Watson, 13; A. J. Gray, b Watson, 36; M. R. Hunt, b Watson, 39; R. Heyland, c, b Watson, 19; C. T. A. James, stpd, b Watson, 2; J. V. T. Harold, not out, 2; J. R. Moffat, not out, 1. Extras, 8. Total, 152. Watson, 6 for 27.

June 6th. v. Middlesex.

Peter Thompson presented a major difficulty by scoring a well-hit 107. This allowed Middlesex to

declare at 191 for 3. Bart.'s showed no signs of retaliation, only Hunt and Stephen reaching double figures. Stephen going in number 7 started slowly, but gained confidence, and remained unbeaten with a hard-earned 62.

Scores: Middlesex 191 for 3 dec.; P. Thompson 107 not out. St. Bartholomew's: J. W. G. Evans, b Wilmot, 8; W. D. Linsell, c Greenish, b Mutch, 3; G. Wells Cole, c and b Wilmot, 5; J. N. H. Jones, run out, 0; M. R. Hunt, c Wilmot, b Loveless, 31; R. M. Mason, b Wilmot, 0; C. S. M. Stephen, not out, 62; P. D. A. Durham, b Wilmot, 5; A. V. Livingstone, b Greenish, 4; A. J. Gray, b Greenish, 6; J. L. Morris, b Greenish,, 0. Extras, 9. Total, 141.

June 13th. v. Public School Wanderers.

The Wanderers batted first and found the Bart.'s bowlers to their liking. P. D. Hayes and A. Ratcliffe both batted confidently, and by tea time the score was 211 for 5. The Wanderers declared here, giving Bart.'s plenty of time for the runs. Linsell and Wells Cole opened the innings and stayed together till 114, when Wells Cole was bowled for 62. Linsell soon followed, and the scoring rate dropped. Heyland and Evans made an unsuccessful bid to beat the clock, the final score being 196 for 6.

Scores: Wanderers 211 for 5; P. D. Hayes 51, A. Ratcliffe 75 not out, P. Hawkes 2 for 23. St. Bartholomew's: W. D. Linsell, c, b Lennard, 68; G. Wells Cole, b Baines, 62; M. R. Hunt, b Lennard, 9; R. Heyland, not out, 29; P. R. Hawkes, c, b Lennard, 8; J. Evans, lbw, b Lennard, 13; J. T. Harold, b Lennard 0; R. J. Randall, V. H. Jones, A. R. Corbett, J. R. Moffat, did not bat. Extras, 7. Total, 196.

Golf

Staff v. Students' Match.

Played on Verulam Golf Course on Wednesday, May 6th, the weather fortunately being most co-operative to the success of the proceedings.

Singles were played in the afternoon, each member of the Staff receiving 2 birdies from their opponents, in which the Staff won by 6 matches to 4.

Foursomes were played after tea, in spite of the absence of certain members of the staff, who were called away by the pressure of work. The Foursomes were again won by the Staff by 2 matches to 1.

Unfortunately, owing to the "austerity" of present rationing arrangements, the club was unable to provide dinner—so no opportunity was given to thank Dr. Graham and the Staff for a most delightful afternoon's play.

Singles—Staff: Prof. Christie, 0; Dr. Morgan + 3/2; Dr. Brander, −; Dr. Graham, − (capt.); Dr. R. J. Alcock, −; Mr. J. Evans, + 6/4; Mr. Robinson, 0; Mr. T. Fison, + 4/2; Mr. Evans, + 1 up; Mr. Rait-Smith, −; C. Routh, + 2 up; Mr. Watson, + 2/1. 6.

Students: A. R. Anderson, 0; N. A. Campbell, −; C. S. M. Stephen, + 2 up; P. Borrie, + 3 up (capt.); J. P. Stephens, + 4 up; A. Livingstone, −; H. Giles, 0; E. J. Holborrow, −; J. C. Barclay, −; R. M. MacPhail, + 2 up; M. F. Bethell, −; W. N. Ingham and T. Brady, −. 4.

Foursomes—Staff: Dr. Graham, Dr. Brander, −; Dr. J. Evans, Mr. Watson, + 2/1; Dr. R. J. Alcock, Dr. Morgan, 0; Mr. Robinson, C. Routh, + 3/2. 2.

Students: P. Borrie, C. S. M. Stephen, + 3/1, A. Livingstone, A. R. Anderson, −; J. P. Stephens, N. A. Campbell, 0; M. F. Bethell, H. Giles, −. 1.

May 30th. v. Radcliffe Hospital, Oxford.

That the team all arrived together in the same train (except one that shall be nameless) could be taken for an omen of success at the start of what proved to be a very pleasant day.

In spite of the heat of the day, such was the enthusiasm that four balled matches were played before tea, the result of which was a draw. After tea those who had not lost all their balls arranged to play singles, in which Bart.'s beat the Radcliffe by 2 up.

Both during and after the game the Oxford team showed the greatest kindness and hospitality—one member of the team indeed was unable to return to London till the following Wednesday.

Team: P. Borrie (capt.), T. Stephens, C. S. M. Stephen, R. M. MacPhail, A. R. Anderson, J. C. Barclay, J. Fison, W. M. Ingham.

Saturday, July 25th. v. Guy's Hospital.

Owing to the rival attractions of more plebeian forms of sport the Bart.'s team, which met a very powerful Guy's Hospital side, was a comparatively weak one. The final score, 4 to 1 in Guy's favour, does not fairly represent the closeness of the individual matches. Only one round of singles was played, as such is the length of the course, that players did not attempt a second in case darkness should overtake them in the rough at the 9th.

Guys: J. W. Drury, − (capt.); R. C. Grant, + 1 up; N. Rankin, + 2/1; N. Whelkton, + 5/4; D. C. Stevens, 0; —. Collins, + 3/2. 4.

St. Bartholomew's: A. R. Anderson, + 1 up; R. M. MacPhail, − (capt); M. S. Hughes; J. C. Barclay, −; W. N. Ingham, 0; T. Brady, 0. 1.

Lawn Tennis

The number of tennis matches this year has been few, due to a large extent to the state of the weather. Three, however, have been played recently. A very depleted side lost to Mary's, 2—7. The following day a match was played against Mr. Fraser's team. A very enjoyable day's tennis was had by everybody, helped considerably by the excellent tea provided by Mrs. White. Bart.'s were successful by 8 matches to 1. Mr. Fraser with Mr. Newbold as his partner scored their side's victory in a real "captain's" match. Our opponents were obviously out of practice, and it was a great pity that the return match was unable to be played.

Teams—St. Bartholomew's: J. P. Stephens, C. S. M. Stephen; Y. Y. Gabril, J. T. Robinson; C. J. Manning, R. Bower. Mr. Fraser's Side: J. Smith, G. Canti; D. Fraser, J. C. Newbold; K. O. Harrison, G. E. Hicks.

8th August.

Bart.'s went down to Hale End for a match against the London Hospital. Rain unfortunately stopped play, with the score at 2 matches all.

Badminton

A badminton court has been erected in the old museum at Bart.'s.

The inaugural meeting of the club was held on July 31st. Dr. Scowen kindly consented to be president of the club. At the meeting the following officers of the club were elected:—Hon. Secretary and Hon. Treasurer, J. H. Gibson. Committee: K. O. Harrison, A. R. Corbett, C. S. M. Stephen.

RELIGION AND MEDICINE

On July 22nd the Revd. Leslie Weatherhead presided at an informal discussion held in the Hospital, the subject being "Co-operation in Religion and Medicine."

In his opening address Mr. Weatherhead gave particulars of his own clinic associated with the City Temple, in which there is active co-operation between the religious psychologist and the medical practitioner. He subsequently answered a bombardment of questions in a lucid manner which affirmed his mastery of the subject.

Disappointment has been expressed by members of the Nursing Staff that they were not invited. Mr. Weatherhead has intimated that he will be delighed to come again and address a mixed meeting.

THE CONJOINT BOARD

Pathology

Shaw, C. H.
Garratt, G. E.
Newcombe, J.
Morgan, L. J.
Squire, J. W.
Mortimer, K. E.
Scott, H. C. L.
Beeston, J.
Attlee, W. O.
Shaw, R. E.
Sanyal, M. C.
Sandiford, R. H.
Haga, P. J.
Singh, S.
Genese, H. N. H.
Weber, M.
Winocour, G.
Manning, C. W. F. S.
Nash, F. A.
Campbell, N. A.
Cook, J. B.
Whelan, W. H.
Boyce, R. McC.
Simmonds, W. B. G.
Coggin Brown, P.

Medicine

Macaulay, J. C.
Leacock, A. G.
Knott, J. M. S.
Kelsey, D. E. R.
Attlee, W. O.
Danby, A. J.
Westwood, J. C. N.
Moon, A. J.
Stewart, J. G.
Collard, P. J.
Shaw, C. H.
Holborow, E. J.
Binns, G. A.
Merryfield, S. J. T.
Brenan, A. H. W.
Shrieber, M.
Townsley, B.
Isenberg, H.
Thursby-Pelham, D. C.
Bevan, J. E. C.
Beeston, J.
Ffrench, G. E.
Andrews, J. N. H.
Campbell, N. A.
Castleden, L. S.
Lucas, R. M.
Hicks, G. E.
Durham, P. D. A.
Langdon, T. C.
Lambley, D. G.
Fluker, J. L.
Nixon, J. C.
Garratt, G. E.
Williams, T. M.
Rees, R. G.
Tadros, V. R.
Thrower, A. L.
Eley, A. J.

Surgery

Allcock, J. M.
Stammers, F. M. G.
Robertson, D. J.
Klein, B.
Davies, T. M.
Beeston, J.
Lemerle, M. E.
Payne, J. C. R.
Williams, T. M.
Pearce, J. F.
Stack, H. G.
Bower, R. J.
Perkins, E. S.
Owlett, R.
McCready, I. A. J.
Sullivan, B.
Whelan, W. H.
Kingdom, I. G.
Sandiford, R. H.
Webb, B. J.
Syed, I. H.
McGrigor, R. B.
Pollack, F.
Morris, J. L.
John, W. R.
Weber, M.
Binns, G. A.
Conway, M.
Moffat, J. R.
Shaw, C. H.
Loosemore, T. G. E.
Banister, E. H. d'A.
Simmonds, W. B. G.

Midwifery

Shaw, C. H.
Johnson, P. F.
Weber, M.
Loosemore, T. G. E.
Payne, J. C. R.
Beeston, J.
Cook, J. B.
Whelan, W. H.
Evans, T. G.
Jones, A. E.
Castleden, L. S.
Newcombe, J.
Lambert, C. L. S.
Street, D. F.
Goldstein, H.
Genese, H. N. H.
Shaw, R. E.
Taylor, G. W.
Kingdom, L. G.
Frampton, H. G.
Weinreb, H.
Conway, M.
Bentall, H. H.
Ramsay, G. S.
Boroda, C.
Tudor, C. E.
Napier, J. R.
Brenman, E.
Bromfield, F. B.
Thomas, M. V. P.
Badock, G. B.
Spencer-Phillips, P. J.
Watkinson, G.
MacKenzie, W.
Philpott, M. G.
Hans, S. F.

The following have completed the examinations for the Diplomas of M.R.C.S., L.R.C.P.:—

Shaw, C. H.
Simmonds, W. B. G.
Holborow, E. J.
Binns, G. A.
Merryfield, S. J. T.
Townsley, B.
Stewart, J. G.
Beven, J. E. C.
Robertson, D. J.
McCready, I. A. J.
Beeston, J.
Haga, P. J.
Ffrench, G. E.
Andrews, J. N. H.
Williams, T. M.
Hicks, G. E.
Thursby-Pelham, D. C.
Pearce, J. F.
Pollak, F.
Attlee, W. O.
Lambley, D. G.
Fluker, J. L.
Nixon, J. C.
Danby, A. J.
Tadros, V. R.
Langdon, T. C.
Stack, H. G.
Owlett, R.
Sanyal, M. C.
Leacock, A. G.
Knott, J. M. S.
Kelsey, D. E. R.
Shrieber, M.
Isenberg, H.
Collard, P. J.
Perkins, E. S.
Klein, B.

BIRTH

HANBURY-WEBBER.—On July 25th, 1942, at Allington House Nursing Home, Ipswich, to Phyllis (née Atkins), wife of Capt. R. Hanbury-Webber, R.A.M.C., a son.

DEATHS

ASTON.—On July 29th, 1942, very suddenly, at Seaview, Isle of Wight, Dr. Richard Norman Aston, beloved and loving husband of Doris Aston.

TAYLOR.—On July 22nd, 1942, at 4, Wicks Lane, Formby, Mark Ronald Taylor, M.R.C.S., L.R.C.P., dear husband of Elizabeth and son of the late Dr. and Mrs. Thomas Taylor, of Bocking, Essex.

Medical Library

OCT 1 1942

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

WAR EDITION

SEPTEMBER 1942

VOL. 3 No. 12.

INDEX

Editorial	189	Book Review	200
The "First M.B.," by J. C. V. Wilkes	194	Hill End News	200
Abernethian Society, by R. J. H. ...	197	Miss Cutler	201
The Brains Trust	198	Correspondence	202
Notes on the Teaching of Ophthalmology, by A. Seymour Philps ...	199	Sports News...	202
		Announcements	204

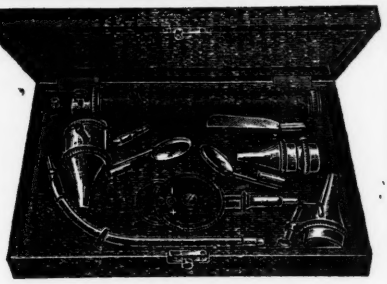
● The same high standard of security and service which characterises "Car and General" Motor Policies applies to every other class of business transacted by the Company. A 'phone call (WHItehall 6161) or a postcard will bring you full information by return.

PERSONAL ACCIDENT • BURGLARY • GOLFERS • Comprehensive Home • FIRE

CAR & GENERAL INSURANCE CORPORATION LTD.

83 PALL MALL, LONDON, S.W.1

Telephone: WHItehall 6161



ELECTRIC DIAGNOSTIC OUTFIT

consisting of auriscope and 3 speculæ May's Opthalmoscope, laryngeal lamp stem to take 2 throat mirrors and tongue spatula.

Medium battery handle 2015 battery and spare lamp - - - **£5 - 14 - 0**

Ditto. with large battery handle and 1829 battery - - - **£6 - 5 - 0**

HOLBORN

SURGICAL INSTRUMENT CO., LTD.

26, Ely Place, Holborn Circus, London, E.C.1

PHONE: HOLBORN 2268

W 214½ STETHOSCOPE St. Bart.'s pattern wide bore head piece, folding spring, red tubing and Skinner's chestpiece with thumb rest and ebonite end to unscrew. **12/6**

W 214 STETHOSCOPE Guy's pattern, with heavy grey tubing and Doherty's all-metal chestpiece with end to unscrew. **14/6**

VERNON'S PERCUSSOR whalebone handle large disc and rubber ring - - **4/6**

STUDENT'S PERCUSSOR metal handle with small disc and rubber ring - - **1/9**

THOMA'S HAEMACYTOMETER with pipettes for red and white corpuscles counting chamber and cover slip in leather case - **43/-**

HEAD MIRROR 3" diameter 7" or 10" focus with fibre head band **16/-**

Ditto, with webbing head band **12/3**

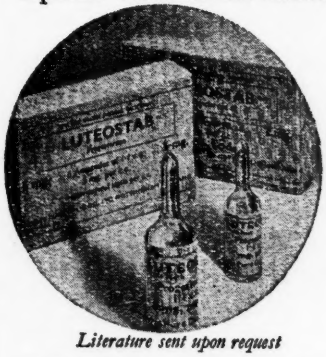
TRADE MARK

LUTEOSTAB

BRAND

Progesterone

Luteostab is a solution of pure crystalline progesterone in oil which is of especial value in the treatment of threatened and habitual abortion. Other clinical applications for Luteostab are menorrhagia, dysmenorrhœa unassociated with uterine hypoplasia, metropathia hæmorrhagica, and sterility due to defective luteinization.



2 mg. (2 International Units)
Box of 6 ampoules - 13/6

5 mg. (5 International Units)
Box of 6 ampoules - 27/-

Prices net to the Medical Profession.

Obtainable through all branches of

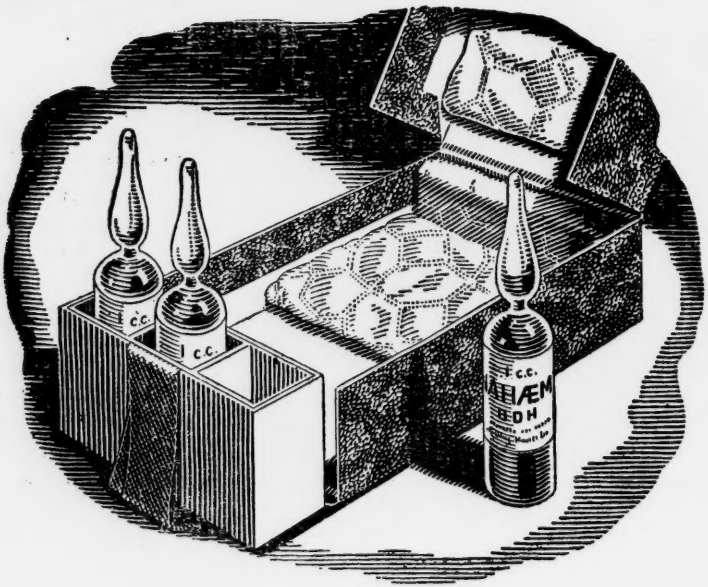
The Boots Chemists

Literature sent upon request

BOOTS PURE DRUG CO. LTD NOTTINGHAM

B775-739A

ANAHÆMIN B.D.H.



Each batch of Anahæmin is subjected to stringent clinical tests in order to ensure maximum potency before issue.

The results of such testing have proved that the effect of a single injection of 2 c.c. Anahæmin in untreated cases of pernicious anæmia of average severity is maintained for not less than two weeks. Hence it is unnecessary to administer Anahæmin more frequently than fortnightly in treatment. In maintenance monthly injections are sufficient.

When wide spacing between injections is desired the "super-concentrate" —Anahæmin—should be employed.

Literature on Anahaemin B.D.H. and Price List of B.D.H. Medical Products will be sent post free on Request

THE BRITISH DRUG HOUSES LTD. LONDON N.1

Telephone : Clerkenwell 3000

Telegrams: Tetradome Telex London

An/85a

The Exoma Press, Ltd., 255/7 Liverpool Rd., N.1.